

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named below. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.



EXPRESS SCRIPTS®
Charting the Future of Pharmacy

6625 W. 78th Street
BL0345
Bloomington, MN 55439
PH # 1-800-417-8164

Prior Authorization Request Form

FAX to ESI: 800-357-9577

Please Note:

If the following information is NOT filled in completely, correctly or legibly,
the authorization review **will be delayed**.

Insurance Company _____

Patients Prescription ID# _____

Patient Full Name _____

Patient Date of Birth _____

Medication Requested _____

Quantity Requested _____ **for** _____ **days supply**

Physician Name (please print clearly) _____

Physician DEA number (required) _____

Physician Address _____

Physician Phone _____

Physician Fax _____

Diagnosis-Indication-Medical History (reason for use of this medication)

Other Medications/Therapies Tried and Reason(s) for Failure _____

Physician Signature _____ **Date** _____

Office Contact Person _____

Any further information pertaining to this drug request should be included and attached to this form.